FILED
BOARD OF OPTOMETRISTS
AUG 12 2002
Susan Gartland
Susan Gartland
Executive Director

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
BOARD OF OPTOMETRISTS

IN THE MATTER OF THE SUSPENSION OR REVOCATION OF THE LICENSE OF HARRY LEVINE, O.D. License No. 0A002237 TO PRACTICE OPTOMETRY IN THE STATE OF NEW JERSEY	Administrative Action FINAL DECISION AND ORDER AFTER HEARING

This matter was opened to the New Jersey Board of Optometrists (hereinafter the "Board") upon the filing of an Administrative Complaint, on April 22, 1999, by John J. Farmer, Jr., Attorney General of New Jersey (hereinafter " the State") by Anthony Kearns, Deputy Attorney General against Respondent Harry Levine, O.D. (hereinafter "Respondent").[1] The Complaint sought the revocation or suspension of the respondent's license to practice Optometry based on his failure to keep complete patient records, his failure to meet the minimum eye examination requirements, and or conduct which constituted gross negligence and gross incompetence, misrepresentation and repeated acts of negligence and incompetence.

The Administrative Complaint alleged that upon receipt of a complaint, from the daughter of one of the respondent's patients, regarding the respondent's care and treatment of her father, Edwin J., the Board requested the Enforcement Bureau of the Division of Consumer Affairs to obtain twenty random patient records from the respondent's office. On or about February 21, 2001

[1] The caption on the administrative complaint reads Harold Levine, O.D. This is incorrect as the respondent's first name is Harry not Harold. This typographical error has been corrected in the Order.

the respondent appeared before the Board and testified under oath, at an investigative inquiry. The respondent testified at the inquiry that he used the direct scale reading of the Schiotz tonometer as the measure of the intraocular pressure of the eye. Respondent only recorded a finding from the tests performed during an examination if the finding "is out of line from what's considered normal." Counts I through XX set forth allegations that the respondent failed to perform the minimum requirements of an eye examination on twenty patients and failed to properly document the patient records. The majority of the 20 patient records included in the complaint lacked a complete history, failed to indicate whether respondent had performed an external and internal eye examination, failed to contain notations regarding objective refractive findings or failed to evaluate ocular motility and the status of binocularity. Color vision testing and visual fields screening were not performed and there was a failure to complete the examination of the anterior segment of the eye. Failure to perform a minimum eye examination on patients and properly record respondent's observations, in violation of N.J.S.A. 13:38-2.1 and 13:38-2.3 were also alleged to constitute gross or repeated acts of negligence, malpractice, or incompetence in violation of N.J.S.A 45: 1-21(c) and (d). It was further alleged that the intra ocular pressure taken with a Schiotz tonometer which was erroneously read, caused respondent to misinterpret the true intraocular pressure resulting in gross or repeated acts of negligence, malpractice, or incompetence in violation of N.J.S.A. 45:1-21(c).

Dr. Levine filed an Answer on October 22, 2001 wherein he denied the allegations in all counts of the Complaint and left the complainant to its proofs.

This matter was originally scheduled for hearing on March 20, 2002 but was adjourned upon the request of the respondent. The matter was rescheduled for hearing on April 17, 2002 but was adjourned as the prosecuting Deputy Attorney General was in a car accident and was unable to appear. A hearing was held before the Board on May 15, 2002. Deputy Attorney General Kenneth

A. Spassione appeared on behalf of the Attorney General and Dr. Harry Levine, O.D. appeared Pro Se. Dr. Levine requested a one day adjournment in order to confer with his daughter (who lives in Israel) about accepting a settlement offer made to him. After considering Dr. Levine's request and the history of this matter which was originally scheduled to be heard in March, 2002 and in view of the serious nature of the charges, the Board voted to deny the request for a one day continuance.

The following documents were accepted and entered into evidence by the Board without objection:

S-1 Copies of twenty (20) patient records from Dr. Levine's office;

S-2 Transcript of an Investigative Inquiry of Harry Levine, O.D., dated February 21, 2001;

S-3 Report of Investigation prepared on October 12, 2000 by Division of Consumer Affairs investigator Allen DeMauro;

S-4 Chart listing twenty (20) patient names and addresses and indicating the testing that was performed on each patient;

S-5 The Enforcement Bureau Board Complaint Transmittal form prepared by Susan H. Gartland, with consumer complaint of Edwin J. attached and the written response from Dr. Levine dated April 8, 2000;

S-6 Patient record of Ed J. prepared on February 24, 2000 by Harry Levine, O.D.;

S-7 Letter from Harry A. Levine, O.D. to the Board dated April 8, 2000 concerning the eye examination of Ed J.;

S-8 Expert Report with attachments prepared by Edward Campell, O,D. dated August 2, 2001;

S-9 Curriculum Vitae of Edward Campbell, O.D. ;

S-10 Memorandum from Susan Gartland, Executive Director of the Board, dated May 14, 2002 outlining the Board's efforts to serve Dr. Levine with notice of the hearing.

Testimony was provided by Susan H. Gartland, Executive Director of the Board regarding

the various correspondence that were served upon Dr. Levine by certified mail, regular mail and hand delivery. Mrs. Gartland corroborated the facts that were described in exhibit S-10 which indicated that notice of the hearing was sent by certified and regular mail on February 21, 2000 for a March 20, 2002 hearing. Both the certified and regular mail were returned to the Board. Mrs. Gartland testified that she had the notice of hearing hand delivered by the Enforcement Bureau to Dr. Levine's home address, at 24 McGuirk Lane, West Orange, NJ 07052. On March 19, 2002 the matter was adjourned upon the respondent's request. This written notice was also sent by certified and regular mail and was not returned to the Board office. On April 29, 2002 a notice was sent to Dr. Levine by certified and regular mail to his home address informing him that the April 17, 2002 hearing was adjourned to May 15, 2002. Mrs. Gartland testified that neither the certified or regular mail was returned to the Board. Although Dr. Levine claimed that he did not receive any of the notices about the various hearing dates he also commented "unless my wife hid my mail, I did not see a single letter." Dr. Levine confirmed that he currently and at the time that the notices of hearing were sent resided at 24 McGuirk Lane, West Orange, NJ. Upon consideration of the testimony of Mrs. Gartland concerning the various written notices provided to the respondent, the Board found that sufficient notice of the hearing was served upon the respondent. (T7,8,9, T10:1-9).

Edward S. Campell, O.D. testified as an expert witness. He has been an optometrist in private practice in Trenton, New Jersey from 1966 to the present and performs approximately 1000 eye examinations every year. He was a member of the VRICS Committee of the National Board of Examiners in Optometry, a member of the New Jersey State Board of Optometrists from 1984-1998, a professional representative for Quality Assurance for Davis Vision from October 1997 to the present and President of the North East Region Clinical Optometric Assessment Testing Service.

Dr. Campell testified regarding the standard of care of optometric practice in New Jersey. He opined that an adequate eye examination in New Jersey is outlined in the Board's minimum examination regulation and includes an external and internal eye exam, requires notation of objective measures of the optics of the eye, binocular testing, measuring of the intraocular eye pressure unless contraindicated and visual field testing (T20:3-10). It also includes taking a complete patient history consisting of the patient's specific eye problem, general health problems, previous eye examinations, past medical history, specific family history of eye diseases and a history of the medications taken by the patient as well as listing medication(s) causing allergic reactions (T20:17-23). According to Dr. Campell optometrists should always note a history of diabetes or hypertension as these conditions and the medications prescribed for them affect the eye (T21:2-23).

Dr. Campell defined an objective examination of the eye to include a retinoscopy. He testified that this examination measures the objective status of the eye to determine whether the patient is nearsighted, farsighted, or has astigmatism (T22:19 -T23:1-2).

He also defined the purpose of a subjective examination of the eye as used to determine the lenses necessary to correct vision, how the eyes operate together, depth perception and binocularity or the use of two eyes for single vision. Movement of the eyes are tested by having the patient follow a moving target with his eyes (T23:20-23).

The intraocular pressure is the pressure within the eye. Dr. Campell testified that it is important to measure intraocular pressure because a high pressure is an indicator of damage to the optic nerve which may lead to glaucoma and to possible permanent eye loss (T24:15-25). According to Dr. Campell intraocular pressure is tested with either a puff tonometer, applanation tonometer attached to a slit lamp or a Schiotz tonometer . The Schiotz tonometer today is more often used by veterinarians and is "rarely used in the standard of care in New Jersey." (T74:7-16,

S-8). Dr. Campell explained that the Schiotz tonometer is used by making an indentation into the cornea and "depending on the pressure within the eye, the further down the indentation goes, the less the pressure, the higher the reading on the scale. " (T25: 5-25). The measurement is read against a chart which provides the actual pressure. Average pressure is between 16-18 millimeters and low pressure is registered at 10 millimeters and below. A low measurement reading is an indicator of high pressure and a high measurement reading is an indicator of low pressure. Without converting the measurement against the chart, an incorrect intraocular pressure is given (T26:1-26).

Dr. Campell also defined an internal eye examination as an observation of the internal part of the eye including the "optic nerve, the retina and the blood vessels on the back of the eye". The internal examination is performed with an ophthalmoscope. It requires dilation of the pupils. Dr. Campell testified that it is standard practice of an optometrist today to dilate a patient's eyes at least once per visit in order to perform a complete eye examination. The only time an optometrist may not dilate the eye is when it is contraindicated by a patient presenting with conjunctivitis or if an individual has "a very narrow angle." (T28:3-7)

Upon further questioning, Dr. Campell testified regarding recordkeeping, that the patient record should contain all pertinent personal information regarding the patient. It should contain results of all pertinent tests performed during the eye examination and all of the components of the minimum eye examination which he discussed previously. Dr. Campell opined that if an optometrist fails to indicate the results of the various tests performed on the patient's eye he will not create a record which can be used in the future to determine changes in the eye (T28:20-25, T29, T30:1-7). It was also Dr. Campell's opinion that to comply with the standards of practice in optometry, an optometrist must perform a complete eye examination before fitting a patient for eyeglasses. He testified that this opinion was based on his experience and practice and standards as established

by the American Optometric Association (T31:1-21).

Dr. Campell also testified that he reviewed the patient records of Edwin J (S-5), a patient of Dr. Levine. The patient records indicated that Edwin J complained that he had a sandy feeling in his eye and his intraocular pressure was noted as 12.0 and 11.0 and that the patient was a diabetic (T33:1-8). Dr. Campbell also testified that Edwin J's patient record did not contain the results of an internal examination of the retina at all (T33:21-25) nor did the record indicate any previous medications or the results of a biomicroscope which is needed to examine the cornea. The examination of the cornea was warranted in Edwin J's case as he complained of a sandy feeling in his eyes (T34:6-20, T35:6-23). Upon further questioning, Dr. Campell imparted to the Board that Edwin J should have had his eyes dilated as he was a diabetic and damage from diabetes is often found in the retina. Therefore, Dr. Campell opined that the respondent's practice "never to dilate" his patients eyes is an extreme deviation from acceptable standards of care for optometrists and this failure poses a risk of harm to the patient. He further testified that dilation allows the optometrist to examine the internal parts of the eye and failure to record changes in the back of the eye because the physician did not see the changes is a serious deviation from the standard of care (T37:2-20). Dr. Campell concluded that the recordkeeping regarding Edwin J. represented a gross deviation from the standard of care (T38: 10-18).

Dr. Campell also found that Edwin J's patient record lacked an external examination of the eyes (T39:5-12) which would have ruled out , or confirmed several causes of a "sandy feeling in his eyes" such as inflammation around the edge of the eyelids which if it caused a discharge would cause a sandy feeling. Therefore, in Dr. Campell's opinion failure to make an external examination would result in a failure to diagnose and also failure to resolve the patient's complaint (T39: 9-23). Thus, Dr. Campell termed the failure to externally examine the eyes a gross deviation from the standard of care (T40:8-13).

Dr. Levine noted in Edwin J's records that he "referred the patient to an M.D. because his pupil's were too small." Dr. Campell analyzed this notation to mean that the respondent had not made an internal examination of Edwin J's eyes which in a diabetic patient is a significant problem because it connotes that the optometrist has not examined the condition of the patient's retina (T40: 3-25). Furthermore, Dr. Campell noted that the patient record did not indicate a finding of cataracts in this patient which could account for small pupils. Additionally, the patient records contained subjective refractive findings but no objective findings were taken or listed (T41:17-24). Edwin J's record indicated that the patient's vision is 20-60 which is less than the legal requirement to drive. The record gives no indication that the patient was notified about his acuity and told not to drive (T42:1-7). The record also is silent as to an evaluation of Edwin J's binocularity or ocular motility. Dr. Campell's opinion was that if "the sandy feeling was due to eye strain, binocular findings become fairly important, as a binocular problem can be one of the leading causes of eye strain." (T42:8-24). Edwin J's record indicated that his tonometric reading was 2. However, as Dr. Levine testified at the inquiry that he uses a Schiotz tonometer and was not aware that he had to convert the measurement using a chart, Dr. Campell concluded that the reading on the patient record was useless and not a true test of the patient's intraocular pressure (T43: 17-25). Furthermore, it was Dr. Campbell's opinion that the respondent's incorrect use of the instrument was "extremely dangerous" because the readings he relied upon were inaccurate, a low reading from the instrument converted to a high intraocular pressure. (T44: 7-14).

Dr. Campell's assessment of the patient care received by Edwin J was that it "was an extreme deviation from the standard of care" (T46:11-14). This patient presented with a complaint of sandy feeling in his eye and he got a prescription for eyeglasses but his problem was neither addressed nor resolved. Thus, he concluded that the respondent's eye examination was grossly inadequate and an extreme deviation from the acceptable standard of care. This patient was a

diabetic and in Dr. Campell's opinion to perform an incomplete examination was dangerous to the patient who may have a sight threatening problem which was not detected (T46:2-21).

Dr. Campell testified that he also reviewed the patient record of Iola G. (S-1) Dr. Campell noted that the patient history is not very complete but does give some idea of the history. The intraocular pressure was a reading of 4.0 in one eye and 3.0 in the other. According to Dr. Campell if these readings were accurate the eye would be "very soft and mushy." Therefore, it was Dr. Campell's opinion that these cannot be true intraocular readings but probably a reading from the Schiotz scale directly which would indicate that the true readings would indicate that the patient had a higher than average intraocular pressure (T47:2-25, T48). The record also failed to contain notations regarding the findings of the internal eye examination which should have been taken on a patient with high intraocular pressure to make sure that the area was healthy and not affected by the high pressure. Iola G's record contains some subjective refractive findings and a prescription with a component for a prism. Dr. Campell testified that prisms are prescribed where there is an imbalance. However, Iola G's record did not support a basis for this prescription (T49: 6-25, T50:1-3). In Dr. Campell's opinion Iola G's patient record was an examination to prescribe eyeglasses and not an eye examination (T50: 7-20). Dr. Campell also concluded that Iola G's record fell far short of the standard of care and contained gross errors (T48:17-21).

Dr. Campell further testified that he also reviewed the patient record of Tomas E (T51). His review determined that the patient history is scanty. Although it provided that the patient is diabetic and that "he takes pills for the diabetes," it did not indicate the name of the medication(s) nor whether the diabetes was controlled or uncontrolled. The record also did not provide information regarding any other health issues. According to Dr. Campell an optometrist is guided by information about the general condition of the eye and about the medications the patient is taking which gives the optometrist a direction as to "certain areas of the eyes" that should be examined

(T51:4-24). Therefore, noting the medications that patient Tomas E. was taking for his diabetes was important. The patient record did not indicate whether an internal eye examination was performed. Again, Dr. Campell opined that this examination was important in an instance where the patient is diabetic since diabetics may suffer from "diabetic retinopathy," a condition which if discovered early is quite treatable and can save the vision. Tomas E.'s patient record also failed to contain information about changes to the retina (T53:1-11). Dr. Campell concluded that the patient record of Tomas E. was not a complete eye examination but a refractive exam and constituted an example of substandard care (T55:3-7).

Upon continued questioning, Dr. Campell was asked to comment upon Dr. Levine's practice to make notations in the patient record only if the findings are not normal (Ta25:3-7 [2]). It was Dr. Campell 's opinion that it is not within acceptable record keeping practice standards to fail to note results of the eye examination. The tests performed on the patient should be reflected on the record. If the record is silent it is Dr. Campell's opinion that the assumption is that the test was not performed. A physician will not be able to recall specific testing performed on a specfic patient on a particular office visit if it is not indicated on the patient's record. Additionally, Dr. Campell noted that the recording of the testing performed is also part of the requirement set forth in the Board minimum examination regulation.

Upon reviewing the patient record of Salvatore G .(S-1), Dr. Campell noted that it contained a brief patient history, no notation about medications taken by the patient, and it indicated that the left eye was removed suddenly but did not explain in the record as to when or the reason for the removal. It is Dr. Campell 's opinion that in the case of a monocular patient performing a complete eye examination becomes even more significant as the patient has only one eye to rely on.

---

[2] References to the transcript from the hearing on May 15, 2002 are refered to as T and references to the transcript from the inquiry on Febuary 21. 2001 are referred to as Ta.

Salvatore G's record contains two tonometric readings as if the patient had two eyes. Dr. Campell found this troublesome, as he reviewed all of the other patient records which consistently listed two readings for patients with two eyes. This inconsistency raised a question in Dr. Campell's mind that "something obviously is not right" with the record. (T58:7-23). Additionally, the record of Salvatore G did not contain a note concerning the external eye examination. Dr. Campell concluded that as this patient record has only one eye, it is extremely important to thoroughly examine the eye inside and out because if the patient loses the vision in that eye, he becomes blind. Therefore, the failure to note an external eye exam is a gross error. As it appears only a refractive examination was done without any eye health testing, for a one-eyed patient; this was termed "gross incompetence" by Dr. Campell (T59:5 to T60:6).

Dr. Campell also testified that he reviewed the patient record of Marge M. He found the patient history to be similar to the other patient histories reviewed. While Dr. Campell found this patient history to be complete, the record indicated that the patient had an exotropia, meaning one of her eyes turned outward, and it was surgically altered (T61:6-25). However, the record made no mention as to whether the patient's eyes are currently straight or not. The record noted reduced visual acuity in the right eye but provided no explanation as to which eye turned in, or to explain the reduced acuity and the reason for it. The record also failed to indicate the previous general health of the patient and contained no information about the health of the patient's eyes (T62:18-25). Dr. Campell again found an incomplete examination (T63:5).

Further questioning of Dr. Campell confirmed that he reviewed an additional 15 patient records including the patient records of Betty M., Frank G., John M.,Marie F., Janice N, Ferdinand N., Rubin N., Michel I, Ray S.,Adele R., Beatrice S., Arlene R., Consuelo, O. George M. and Angelina M. (S-1). He testified that in general these patient records were grossly inadequate. As a whole the eye examinations contained in these patient records were no more that refractive

examinations for the determination of an eyeglass prescription with very little care being paid to the patient's eye health. (T65:1-15). It was Dr. Campell's opinion that these sixteen records were incomplete eye examinations, were unacceptable and failed to meet most of the items required by the Board's minimum examination regulation, N.J.A.C. 13:38-2.1 (T68:2-16). Furthermore, Dr. Campell testified that in his opinion the respondent's conduct constituted gross incompetence and gross negligence in the performance and the recording of the incomplete eye examinations. Dr. Campell prepared a chart of each patient which highlights the tests that were performed and those that were left out. A review of the chart (S-8,p.7) demonstrates that Dr. Campell put the letter "Y" in the box for the tests that were performed and the letter "N" for the procedures that were not performed. A review of the chart demonstrates that you will find more "Ns" than "Ys" were marked for each patient reviewed. Dr. Campell testified that the eye examinations provided by Dr. Levine did not meet the standard of care as the records were inadequate, provided only a prescription for eyeglasses and failed to document the eye health of the patients (T71:6-25). Respondent's failure to dilate the patients was also problematic and contrary to the standard of care. Failure to dilate the eyes resulted in an improper examination of the internal parts of the eye (T73:4-19). Respondent also failed to measure the accurate intraocular pressure of his patient's eyes as he failed to understand the proper working of a Schiotz tonometer. He was using a tonometer which is rarely used on human patients in New Jersey. This was further compounded by respondent's failure to properly use the tonometer correctly as he was not aware of the need to convert the reading from the instrument against a chart. Therefore, the intraocular pressure of the patients that he measured were incorrect (T74:3-25).

Dr. Levine did not cross examine Dr. Campell and placed a statement on the record that he relied upon his testimony to the Board at the investigative inquiry (S-2) and that he provided the best examination to his patients that he was capable of. (T78: 9-19). At the February, 2001

inquiry Dr. Levine was asked whether he ever dilated any of his patient's eye. His response was "No, if I find there is a problem, I'll refer them out." (Ta18:16-20). Upon questioning concerning the patient record of Edwin J, and whether Dr. Levine performed fusion or stereo color and field testing, the respondent's response was that " in most cases he ran the tests, I only record abnormalities (Ta23:13-17). He further confirmed that if the test was "within normal range" he did not record it on the patient record (Ta23:18-23). Dr. Levine also testified that he noted on the patient record of Tomas E. that "he's diabetic and that he takes pills, pills for diabetes. This was the only information that the patient gave me." (Ta24:10-16). When questioned as to whether Dr. Levine was aware of the specific medication that Tomas E. was taking he responded that he did not know and that often patients do not know the specific name of the medication. Upon general questioning regarding medications for arthritis, diabetes, and high pressure, Dr. Levine was asked whether he was aware if any of the medication for these diseases had ocular side effects. His response was "Not offhand. I'm not extremely familiar with pharmacology. So I record the information that the patients give me. "(Ta35:15-22)

Dr. Levine was asked whether he was aware that a Schiotz tonometer reading must be converted by using a chart to determine the pressure. The respondent stated that he "certainly wasn't aware of that, that 's not what I've been taught. I must confess that wasn't part of my education, it was my understanding that the reading of the Schiotz was the pressure."(Ta29:4-17).

Dr. Levine also testified that the patient record of Tomas E. did not indicate any findings from the external eye examination. Dr. Levine response was that "the patient offered no visual complaints. I feel that it is a normal evaluation, I generally do not make any recording, it's only when something is out of line that I'll note it." (Ta25:1-7). It was Dr. Levine's testimony that he performed an external and internal examination of the eyes of Tomas E. but he did not record any findings because "there was nothing out of line." When asked if he perfomed a keratometry, he

responded that he did not know, " I did not see it on here so I am not sure if I did it or not." (Ta25:20-23). Furthermore, he testified that he performed a retinoscopy on Tomas E. but he did not record any objective or subjective findings because ' I didn't feel that it was necessary." (Ta26:14-25). In closing, Dr. Levine informed the Board at the inquiry that "I've been practicing for a long time, which is not significant but I feel that I give every patient the very best that I am capable of. I have never yet short changed any patient as far as time or as far as cutting back on testing and everything else. I do what I feel will give me the most and best accurate information to give the best possible prescription to the patients." (Ta42:6-13).

Regarding any costs that might be imposed upon him, Dr. Levine testified that he is "flat broke" and has no income. (T79:2-14)

The Board conducted its deliberations of the evidence and testimony before it in Executive Session on May 15, 2002, and announced its decision in Public Session on the same date. The board sent a letter by certified mail and regular mail to respondent on June 27, 2002 explaining the compostion and the amount of costs requested in this matter and allowing him to comment on the amount of costs. The Board reviewed the letter at its July 17, 2002 meeting and considered that the respondent did not submit a response. The Board also noted that the certified mail was returned as unclaimed but the regular mail was not returned. The Board voted to affirm the costs that were requested. This order memorializes the Board's determination.

FINDING OF FACTS

1. Harry Levine, O.D. is the holder of a license to practice optometry in New Jersey and has been licensed at all times pertinent to the Complaint.

2. The method used by the respondent to obtain a reading of intraocular pressure from the

Schiotz tonometer without use of a conversion table is incorrect. The intraocular pressure that he noted on his patient records was inaccurate.

3. The respondent's practice to record only findings which are abnormal is a deviation from the standard of practice and the record keeping regulation of the Board.

4. On August 8, 2000 respondent failed to perform a minimum eye examination for patient Salvatore G. by failing to obtain a complete history, failing to perform a complete examination of the external eye and adnexae or of the internal parts of the eye; failing to observe or record objective refractive findings, failing to perform color vision testing, visual fields screening or to complete the examination of the anterior segment of the eye using a biomicroscope or other equivalent equipment, failing to evaluate or record ocular motility and status of binocularity and failing to record notations in the patient record regarding medications taken by the patient and to note that the patient had one eye.

5. The eye examination performed on 15 other patients including Billy M., Frank G., John M., Marie F.,Janice N.. Fernanda N., Richard N., Michael N., Roy S., Adele R, Beatrice S., Arlene R., Consualo O., George M. and Anglica M. were also incomplete and inadequate and did not meet the minimum requirements of an eye examination. The examinations were refractive exams for the determination of an eyeglass prescription with little attention paid to the patient's eye health.

6. Respondent did not dilate the eyes of any of the patients that he examined. Without dilation a proper examination of the internal parts of the eyes cannot be performed.

7. On March 30, 1999 respondent performed an eye examination for Iola G. This eye examination was incomplete as respondent failed to perform an exam of the external eye and adnexae, the internal parts of the eye, failed to observe objective refractive findings, failed to evaluate the ocular motility and the status of binocularity; failed to perform color vision testing or visual fields screening, failed to complete the examination of the anterior segment of the eye using

a biomicroscope. Respondent also failed to record his findings from the eye examination.

8. The intraocular readings recorded by respondent for patient Iola G. using a Schiotz tonometer were inaccurate as the respondent failed to convert the reading against a chart.

9. On August 8, 2000 the respondent failed to perform a minimum eye examination for Tomas E., a diabetic patient. The record of Tomas E. is incomplete as it contains a sketchy history, fails to note any medications for diabetes and whether the patient's diabetes is under control, failed to complete the examination of the external eye and adnexae, failed to complete the exam of the internal parts of the eye, failed to observe and record objective refractive findings, failed to evaluate or record motility and status of binocularity, failed to perform color vision testing and visual fields screening and failed to complete the examination of the anterior segment fo the eye using a biomicroscope.

10. The respondent performed an incomplete eye examination of Mujihur M. on May 27, 2000 by his failure to perform a complete exam of the external eye and adnexae, failure to examine the internal parts of the eye, failure to observe and record objective findings, failure to evaluate or record ocular motility and binocularity, failure to perform color vision testing or visual field screening.

CONCLUSIONS OF LAW

1. The respondent's failure to perform eye examinations which complied with the minimum examination regulation pursuant to N.J.A.C. 13:38-2.1 constitutes gross negligence and incompetence and repeated acts of negligence and incompetence in violation of N.J.S.A. 45:1-21(c) and (d).

2. The respondent's findings of the intraocular pressure of both eyes of patient, Salvatore

G. when the record reflected that the patient's left eye was enucleated constitutes misrepresentation in violation of N.J.S.A. 45:1-21(b) as well as a violation of substandard record keeping in violation of N.J.A.C. 13:38-2.3.

3. Respondent's misinterpretation of the true intraocular pressure as a result of erroneous reading of the Schiotz tonometer during the course of the examination of patients Thomas E., Fernanda N., John M., Marge M., Richard N., Michael N., Beatrice S., Consualo O., Arlene R., Roy S., Angelica M., George M., Jackie N., Frank G. and Adele R constituted gross negligence and incompetence and repeated acts of negligence and incompetence in violation of N.J.S.A. 45:1-21(c) and (d).

4. Respondent's failure to perform dilation on Thomas E., Frank G., and John M., who were diabetics, for early diagnosis of Proliferation of Diabetic Retinopathy or to refer these three patients to another doctor for such examination also constituted gross negligence and gross incompetence in violation of N.J.S.A. 45:1-21(c).

5. Respondent's failure to document the complete findings of his patients eye examinations and his failure to note the names of the medications taken by the patients on all twenty patient records constituted violations of N.J.A.C. 13:38-2.3

DISCUSSION

This matter involves a practitioner who has demonstrated an ignorance of current practice standards and whose practice as demonstrated on this record, involves incompetence so serious that it endangers the ocular health of his patients. In coming to this conclusion and in determining the measure of discipline to impose, the Board relied upon the testimony of Dr. Campell with which in its own expertise the Board agrees. Dr. Campell testified that Dr. Levine's practice to never

dilate the eyes of any patient failed to meet the acceptable standard of care. Additionally, the Board weighed the number of required elements set forth in the minimum eye examination regulation and noted that the number of deficiencies found in the twenty patient records were substantial. Coupled with Dr. Levine's failure to note medications that his patients were taking and his erroneous reading of the Schiotz tonometer, this resulted in the Board's conclusion that his performance constituted repeated incompetence and gross negligence. Furthermore, the Board agreed with Dr. Campell's assessment that the eye examinations received by Dr. Levine's twenty patients (S-1) were incomplete, inadequate and failed to diagnose the eye health of the patients. The Board was also concerned with Dr. Levine's failure to record any findings in his patient's records unless the findings made were abnormal. This conduct does not comply with the common standards of practice and constitutes repeated incompetence. The respondent's failure to record findings from his patients examinations resulted in records that fail to provide information regarding any changes to the patient's eye health which is a serious deviation from the standard of care. Dr. Levine's lack of familiarity with medications taken by his patients for arthritis, hypertension and diabetes is a serious deficiency. His ignorance concerning the ocular side effects of these medications placed the eye health of his patients in jeopardy. Furthermore, respondent's failure to perform examinations of the interior part of the eye in diabetic patients without examining the condition of the retina constituted gross negligence. The Board considered that the respondent has a limited income but feels that due to his lack of basic knowledge necessary to practice, it must require that the respondent's license to practice optometry be revoked.

Therefore, in accordance with the Board's findings herein and for other good cause shown;

IT IS on this 12th day of ~~June~~ August, 2002,

ORDERED that:

1. The license of the respondent to practice Optometry shall be revoked. Respondent shall immediately cease and desist from the practice of optometry. Respondent is to return the certificate of registration immediately upon receipt of this Order to Susan Gartland, Executive Director, 124 Halsey Street, P.O. Box 45012, Newark, New Jersey 07101.

2. The Board imposes a civil penalty in the amount of $15,000 for the violations as detailed above. This penalty shall be stayed as long as Dr. Levine ceases from engaging in the practice of optometry and abides by the provisions of this order.

3. Respondent is assessed costs to the State in the amount of $20,421.69. These costs represent the costs for the transcriber and the transcripts from the investigative inquiry held on February 21, 2001 (in the amount of $708.00) and the May 15, 2002 hearing (in the amount of $1096.00), the cost of the investigation in the amount of $1687.69, $1000.00 for the cost of the expert witness and attorney fees in the amount of $15,930. Attached as Exhibit A are certifications of costs. Said costs shall be submitted by certified check or money order made payable to the State of New Jersey and submitted to the attention of Susan Gartland, Executive Director, State Board of Optometrists, 124 Halsey Street, P.O. Box 45012, Newark, New Jersey 07101 no later than thirty (30) days following the entry date of this Order.

NEW JERSEY STATE BOARD OF OPTOMETRISTS

BY: 

Leonard Steiner, O.D.
President

DAVID SAMSON
ATTORNEY GENERAL OF NEW JERSEY
Division of Law, 5th Floor
124 Halsey Street
P.O. Box 45029
Newark, New Jersey 07101
Attorney for Plaintiffs
Division of Consumer Affairs

By: Kenneth A. Spassione Jr.
Deputy Attorney General
Tel. (973) 648-2972

STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF OPTOMETRISTS

In the Matter of the Suspension or Revocation of the Licence of HARRY LEVINE O.D., License No. OA002237 To Practice Optometry in the State of New Jersey	Administrative Action CERTIFICATION OF ATTORNEY FEES

Kenneth A. Spassione, Jr., of full age, hereby certifies in lieu of oath pursuant to R. 1:4-4(b), as follows:

1. I am a Deputy Attorney General assigned to the New Jersey Division of Law, Consumer Affairs Prosecutions Section. I make this Certification in support of the Attorney General's application for attorney fees in this matter.

2. I was admitted to practice law in New Jersey in 1997.

3. Deputy Attorney General Anthony Kearns, III previously handled this matter. He was assigned this matter on June 11, 2001. and he directed the investigation in this matter. Anthony Kearns, III certifies under separate application that he expended 24.8 hours in connection with this matter. Annexed is a copy of his certification and billing records for this matter. $2,480.00 is to be paid by the Division of Consumer Affairs, Board of Optometry to the Division of Law for his work on this matter.

4. This matter was reassigned to me on November 29, 2001. The amount of time expended by me in connection with this matter from November 29, 2001 until May 14, 2002, totals 157.3 hours. Annexed is a copy of my billing records on this matter. $8,234.88 is the actual cost paid by the Division of Consumer Affairs to the Division of Law in this matter.

5. The Division of Consumer Affairs, Board of Optometry is billed approximately $100.00 for both my work and the work of DAG Kearns. The calculations for the time expended by both DAG Kearns and myself are:

DAG Kearns: 24.8 Hours x $100.00 per hour = $2,480

DAG Spassione 132.5 Hours x $ 100.00 per hour = $ 13,250

TOTAL: $ 15, 730

6. The time recorded on the attachment reflects time spent reviewing documents, correspondence, research, expert witness preparation, telephone conferences and three instances of trial preparation time. The time record does not reflect time spent subsequent to May 14, 2002.

7. The following is the explanation for each code:

CMS	Miscellaneous (includes correspondence, phone calls, research)
CPR	Trial Preparation
CRW	Research/Writing
CDR	Document Review
CAP	Appearance

8. Since May 14, 2002, I have spent an additional two hours on this matter:

May 23, 2002, one hour, preparing attorney time summary

May 28, 2002, one hour, drafting of certification

9. The Division of Consumer Affairs, Board of Optometry was billed an additional $200.00 for the two hours that I worked on this matter since May 14, 2002. ($100 x 2 = $200.00). When added to the above total for the hours spent by DAG Kearns and myself, the Grand Total for all attorney's costs in this matter is $ 15,930.00

DIVISION OF LAW TIMEKEEPING SYSTEM
TIME DISPLAY REPORT

EMP NUM	ACTIVITY DATE	ACT CODE	TIME	MATTER NUM	BILL CODE	SUBCODE
S31	12/04/2001	CRW	2.5	01-51247	OPT	
	12/07/2001	CRW	2.0	01-51247	OPT	
	12/12/2001	CMS	1.0	01-51247	OPT	
	01/02/2002	CMS	2.0	01-51247	OPT	
	02/07/2002	CRW	2.0	01-51247	OPT	
	02/11/2002	CPR	3.0	01-51247	OPT	
	02/12/2002	CDR	4.0	01-51247	OPT	
	02/13/2002	CMS	3.0	01-51247	OPT	
	02/14/2002	CPR	3.0	01-51247	OPT	
	02/15/2002	CPR	4.0	01-51247	OPT	
	02/18/2002	CPR	5.0	01-51247	OPT	
		CPR	1.5	01-51247	OPT	
	02/19/2002	CMS	2.0	01-51247	OPT	
	02/21/2002	CRW	4.0	01-51247	OPT	
	02/22/2002	CMS	4.0	01-51247	OPT	
	02/25/2002	CMS	3.0	01-51247	OPT	
	02/26/2002	CPR	5.0	01-51247	OPT	
	02/27/2002	CPR	4.0	01-51247	OPT	
	02/28/2002	CPR	4.0	01-51247	OPT	
	03/01/2002	CPR	4.5	01-51247	OPT	
	03/11/2002	CPR	1.5	01-51247	OPT	
	03/12/2002	CPR	1.5	01-51247	OPT	
	04/01/2002	CPR	4.0	01-51247	OPT	
	04/02/2002	CDR	3.0	01-51247	OPT	
	04/03/2002	CPR	4.0	01-51247	OPT	
	04/04/2002	CPR	2.0	01-51247	OPT	
	04/08/2002	CRW	2.0	01-51247	OPT	
	04/09/2002	CPR	2.0	01-51247	OPT	

DIVISION OF LAW TIMEKEEPING SYSTEM
TIME DISPLAY REPORT

EMP NUM	ACTIVITY DATE	ACT CODE	TIME	MATTER NUM	BILL CODE	SUBCODE
S31	04/10/2002	CPR	3.0	01-51247	OPT	
	04/11/2002	CPR	4.0	01-51247	OPT	
	04/15/2002	CPR	8.0	01-51247	OPT	
	04/23/2002	CPR	2.0	01-51247	OPT	
	04/26/2002	CDR	2.0	01-51247	OPT	
	04/29/2002	CRW	2.5	01-51247	OPT	
	04/30/2002	CPR	2.0	01-51247	OPT	
	05/03/2002	CPR	2.0	01-51247	OPT	
	05/08/2002	CPR	1.5	01-51247	OPT	
	05/09/2002	CPR	1.0	01-51247	OPT	
	05/10/2002	CPR	3.0	01-51247	OPT	
	05/13/2002	CPR	5.0	01-51247	OPT	
	05/14/2002	CPR	6.0	01-51247	OPT	
	05/15/2002	CAP	7.0	01-51247	OPT	

DAVID SAMSON
ATTORNEY GENERAL OF NEW JERSEY
Division of Law, 5th Floor
124 Halsey Street
P.O. Box 45029
Newark, New Jersey 07101
Attorney for Plaintiffs
Division of Consumer Affairs

By: Anthony P. Kearns, III
Deputy Attorney General
Tel. (973) 648-4737

STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF OPTOMETRISTS

In the Matter of the Suspension or Revocation of the Licence of HARRY LEVINE O.D., License No. OA002237 To Practice Optometry in the State of New Jersey	:	Administrative Action CERTIFICATION OF ATTORNEY FEES

I, Anthony P. Kearns, III, of full age, hereby certifies in lieu of oath pursuant to R. 1:4-4(b), as follows:

1. I am a Deputy Attorney General assigned to the New Jersey Division of Law, Consumer Affairs Prosecutions Section. I make this Certification in support of the Attorney General's application for attorney fees in this matter.

2. I was admitted to practice in New Jersey in 1998.

3. I was assigned to this matter on June 11, 2001. I directed the investigation and prepared the complaint filed before the Board of Optometry.

4. I expended 24.8 hours in connection with this matter. Annexed is a copy of billing records for this matter. $2,480.00 is to be paid by the Division of Consumer Affairs, Board of Optometry to the Division of Law for my work on this matter. The following is the explanation for each code:

CMS	Miscellaneous (includes correspondence, phone calls, research)
CPR	Trial Preparation
CRW	Research/Writing
CDR	Document Review
CCR	Correspondence

5. The Division of Consumer Affairs, Board of Optometry is billed approximately $100.00 per hour for my work. The calculations for my time are as follows:

DAG Kearns: 24.8 Hours x $100.00 per hour = $2,480

6. The time recorded on the attachment reflects time spent reviewing documents, drafting the complaint, correspondence, research, expert witness preparation, telephone conferences.

7. This matter was reassigned to DAG Kenneth A. Spassione Jr. on November 29, 2001 whose hours are certified to under separate application.

I hereby certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are wilfully false, I am subject to punishment.

By: _____
Anthony P. Kearns, III.
Deputy Attorney General

Date:

Att.: Printout from State of New Jersey Timekeeping system of hours expended by Anthony P. Kearns, III on the above captioned matter.

DIVISION OF LAW TIMEKEEPING SYSTEM
TIME DISPLAY REPORT

EMP NUM	ACTIVITY DATE	ACT CODE	TIME	MATTER NUM	BILL CODE	SUBCODE
N45	07/30/2001	CRW	.8	01-51247	OPT	
	07/31/2001	CDR	2.9	01-51247	OPT	
	08/01/2001	CCM	.4	01-51247	OPT	
	08/02/2001	CDR	2.1	01-51247	OPT	
		CCM	.9	01-51247	OPT	
	09/19/2001	CDR	2.8	01-51247	OPT	
	09/20/2001	CDR	3.8	01-51247	OPT	
		CRW	3.4	01-51247	OPT	
	09/21/2001	CRW	3.4	01-51247	OPT	
	09/24/2001	CCM	.5	01-51247	OPT	
		CRW	3.1	01-51247	OPT	
	10/03/2001	CCM	.4	01-51247	OPT	
	10/26/2001	CCR	.3	01-51247	OPT	

STATE OF NEW JERSEY
DEPARTMENT OF LAW AND PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF OPTOMETRISTS

HARRY LEVINE, O.D. LICENSE NO. 2237	:	Administrative Action Certification of Costs

Susan H. Gartland, of full age, hereby certifies and say:

1. I am the Executive Director of the New Jersey State Board of Optometrists (the "Board"), having offices at 124 Halsey Street, Newark, New Jersey 07102, and am the official custodian of the records of the Board.

2. I have directed that a diligent search be made of the Board records in the above captioned matter relative to certified costs incurred by the Board in its administrative proceedings. Costs incurred by the Board during its investigation of this matter total the amount of $1,687.69. Costs incurred by the Board for the report and testimony of expert, Edward S. Campell, O.D., in this matter total the amount of $1,000.00. Costs incurred by the Board for the court reporter and the transcript for the February 21, 2001 Investigative Inquiry and the May 15, 2002 Hearing in this matter total the amount of $1804.00.

I hereby certify that the foregoing statements made by me are true and I am aware that if any of the foregoing statements are willfully false, I am subject to punishment.

Susan H. Gartland

Susan H. Gartland, Executive Director

Dated:
June 18, 2002